STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE AT SOLARBRON THE	1701 MCDOWELL RD EVANSVILLE, IN 47712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: June 4, 5, 6, 7, 8, 11, 12, 13, 2012 Facility number: 010930 Provider number: 155773 AIM number: N/A Survey team: Amy Wininger, RN, TC Diane Hancock, RN (June 4, 5, 6, 7, 8, 11, 12, 2012) Vickie Ellis, RN Barbara Fowler, RN Census bed type: SNF: 33 Residential: 29 Total: 62 Census payor type: Medicare: 19 Other: 43 Total: 62 Residential sample: 7 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	Bysubmitting the enclosed material we are not admitting the truth oraccuracy of any specific findings or allegations. We reserve theright to contest the findings or allegations as part of anyproceedings and submit these responses pursuant to our regulatoryobligations. The facility request that the plan of correction beconsidered our allegation of compliance effective July 16, 2012 tothe annual licensure survey conducted on June 4 through June 13, 2012	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	Quality review 6/19/12 by Suzanne Williams, RN			

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on observation, interview and record review, the facility failed to ensure the physician and family were notified of a significant weight loss, for 1 of 3 residents reviewed for weight	F0157	**F157** ***Whatcorrective action(s) will be accomplished for those residents foundto have been affected by the deficient practice?***	07/16/2012

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	loss in a sample of 3 who met the criteria for weight loss. (Resident #31) Finding includes: Resident #31's clinical record was reviewed on 6/6/12 at 2:45 p.m. The record indicated the resident was re-admitted on 5/11/12. Diagnoses included, but were not limited to, general debility, status/post valve replacement on coumadin [blood thinner], urinary retention, congestive heart failure, hypertension, chronic back pain, anemia, pneumonia, depression, and heart disease. Physician's orders, signed 5/29/12, indicated the resident was on a regular diet as of 5/16/12. Orders for Speech Therapy for swallow evaluation and treatment were obtained on 5/22/12. On 6/7/12 at 12:08 p.m., the resident's lunch tray was observed on the overbed table, covered. A laboratory technician was drawing blood. The Speech Therapist entered the room. She was interviewed on 6/7/12 at 12:12 p.m. She indicated she evaluated the resident for swallowing at first, but discontinued		It is the practice Solarbron to assure that thephysician and family are notified appropriately in accordance withthe guidelines including significant weight loss. The corrective action taken for those residents found tobe affected by the alleged deficient practice include: Resident#31 physician and family have been notified appropriately related tothe resident's current weight. ***How will other residents having the potentialto be affected by the same deficient practice be identified and whatcorrective actions will be taken?*** Other residents that have the potential to be affectedhave been identified by: All residents will be reviewed to assure thatphysician/families have been notified appropriately of any changesincluding significant weight loss. ***What measures will be put into place or whatsystemic changes will be made to ensure that the deficient practicedoes not recur?*** The measures or systematic changes that have been putinto place to ensure that the alleged deficient practice does notrecur include: Allnurses will be in-serviced relating to the importance ofphysician/family notification with significant changes including thepresence of weight loss. As the interdisciplinary team reviews	

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	because he was swallowing well and was only treating him for cognitive improvement. She indicated she was just checking on him that day because he had a spell where he was slurring that morning and she was concerned. Dietitian notes dated 5/31/12 at 12:35 p.m. indicated the following: "Resident's wt [weight] 5/30/12 189.8 lbs [down] 15 lbs X 1 wk. On regular diet with intakes 50-100% of meals. On Lasix [diuretic medication] 20 mg QD (has been since adm). IBW [Ideal Body Weight] 200 +/- 5 lbs. Will have nursing assess and notify MD." 6/4/12 1047 [10:47 a.m.] "...Wt 6/3/12 191.2 lbs [up] 1.4 lbs X 4 days." The nurses' notes were reviewed, at that time, and there was no indication the physician was notified or nursing assessed. LPN #1 was interviewed on 6/7/12 at 2:25 p.m. She indicated the resident was a daily weight and his weight was 187.2 pounds on that date. On 6/7/12 at 4:00 p.m., Resident #31's record was reviewed again. There was no indication the physician was called for weight loss. A		anyresidents with weight loss as well as any other type of significantchange, they are reviewing all documentation to assure that thephysician/family was notified appropriately. The dietician has beennotified that they are to notify nursing administration of anyidentified weight loss with recommendations. ***How will thecorrective action be monitored to ensure the deficient practice willnot recur, ie, what quality assurance program will be put into place?*** The corrective action taken to monitor performance toassure compliance through quality assurance is: APerformance Improvement Tool has been initiated that will be utilizedto review weight losses to assure that the physician/family have beennotified in accordance with the regulation. The tool will randomlyreview 5 residents (if applicable) with known weight loss. NursingAdministration, or designee, will complete this audit weekly x3,monthly x3, then quarterly x3. Any issue identified will beimmediately corrected. The Quality Assurance Committee will reviewthe tool at the scheduled meeting following the completion of thetool with recommendations as needed. ***Thedate the systemic changes will be completed:*** July16, 2012	

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	Registered Dietitian note, dated 6/7/12 at 11:03 a.m., indicated, "Resident's wt 6/6/12 186.2 lbs [down] 3.6 lbs X 1 wk, [down] 22.2 lbs since adm [admission]. Will request med pass [nutritional supplement] 90 cc [cubic centimeters] TID [three times a day] d/t [due to] wt. loss. Regular diet. Intakes generally 50-100% of meals." On 6/8/12 at 10:00 a.m., LPN #2 was interviewed. She indicated when the dietitian made recommendations, she often faxed them herself to the physician. She reviewed the record to see if the physician had been notified on 5/31/12 about the resident's weight loss. She reviewed a folder with faxes in it. She indicated he was not eating well when he first got to the facility and had a lot of fluid taken off during his last hospitalization, prior to admission. She further indicated she usually worked evenings, so notification of the physician was not always passed on. On 6/8/12 at 10:10 a.m., the Registered Dietitian was interviewed and indicated she reviewed the resident last week and wrote the note and asked nursing to assess the resident and notify the physician.			

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	She indicated she was then off work. She re-evaluated him this week and he had more weight loss. She recommended adding med pass supplement due to continued weight loss. She indicated she spoke to LPN #1, the nurse that day, and LPN #1 said she had a call out to the doctor and would also request the supplement for the resident when the doctor called back. Review at the time revealed no documentation of the physician being notified of the weight loss. He had been notified of a change in behavior and had ordered some labwork. No orders for supplement were noted. The policy and procedure for Change of Condition Notification, dated 2003, was provided by the Director of Nurses on 6/7/12 at 12:46 p.m. The policy indicated, "It is the policy of this facility to notify the Resident, Resident's Physician, Resident's legal representative or interested family member when there is a change in the Resident's condition." "Areas that require notification of the Physician, Resident, Resident's legal representative and/or interested family member: ...Weight loss." 3.1-5(a)(2) 3.1-5(a)(3)			

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F0272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. Based on interview, observation, and record review, the facility failed to identify the lack of dentures on the comprehensive assessment, for 1 of 3 residents reviewed for dental needs, in a sample of 6 that met the criteria. (Resident #44)	F0272	**F272** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** It is the practice of this facility to assure thatresidents are assessed appropriately in accordance with ability to eat and the presence or absence of	07/16/2012

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	Finding includes: During observation on 6/5/12 at 9:07 a.m., Resident #44 had only one bottom tooth present and no upper teeth. During an interview on 6/5/12 at 9:07 a.m., Resident #44 indicated he had upper dentures and a partial denture plate for the bottom. Resident #44 indicated he did not wear his dentures as his dentures were too loose and did not fit any longer. Resident #44 indicated no one at the facility had asked him about his loose fitting dentures. Resident #44's record was reviewed on 6/6/12 at 1:00 p.m. Resident #44 was admitted to the facility on 5/8/12 and had a care plan for nutrition related to his diabetes mellitus, hypertension, and right below the knee amputation. There was no documentation in the dietary notes or the social service notes regarding the resident's loose fitting dentures or edentulous state. The MDS [Minimum Data Set] assessment, dated 5/15/12, indicated the resident did not have any dental		dentures. The correction action taken for those residents found to be affected by the alleged deficient practice include: Resident #44 no longer resides at facility. ***How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?*** Other residents that have the potential to be affected will be identified by: All residents with dentures/partial plates will be assessed to ensure they fit properly and the resident has no concerns with eating. These resident's will be care planned for dentures/partial plates. The MDS summaries have been updated to reflect the appropriate oral assessment. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** The measures or systematic changes that have been put into place to ensure that the alleged eficient practice does not recur include: The MDS nurse and nursing staff will be in-serviced and are responsible for assuring that the assessments are correct and accurate to reflect the resident's condition during the assessment period including the use of dentures. The MDS Summary Form has been updated to include language directly from the RAI Manual to ensure accuracy. ***How will the corrective action***	

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	issues. 3.1-31(c)(9)		***be monitored to ensure the deficient practice willnot recur, ie, what quality assurance program will be put into place?*** The corrective action taken to monitor performance toassure compliance through quality assurance is:A Performance Improvement Tool has been initiated that will be utilizedto review resident's assessment to assure that they are correct andaccurately reflect the residents' conditions. These tools willrandomly review 5 residents. The Director of Nursing, or designee,will complete the tools weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately addressed. The QualityAssurance Committee will review the tools at the scheduled meetingfollowing the completion of the tool with recommendations as needed. ***Thedate the systemic changes will be completed:*** July16, 2012	

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure services were provided in accordance with the plan of care for 2 of 26 residents reviewed for following the plan of care, in that, Resident #73 did not receive a bedtime snack and Resident #138 did not have dermasavers applied according to the plan of care. (Resident #73, Resident #138) Findings include: 1. Resident #73's clinical record was reviewed on 6/6/12 at 2:45 p.m. Resident #73 was admitted on 3/19/12 with a diagnoses including, but not limited to, general debility and diabetes mellitus. Resident #73 was currently receiving Lantus insulin, Januvia, and Glucophage used for the treatment of diabetes mellitus. A physician's order dated 4/6/12 indicated Resident #73 was to be weighed daily. Resident #73 had a physician's order indicating the resident was to be up with a gait belt,	F0282	**F282** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** Itis the practice of Solarbron to assure that all services that are provided are completed in a manner that is in accordance with theplan of care. The correction action taken for those residents found tobe affected by the alleged deficient practice include: Resident#73 receives the bedtime snack and is offered replacements ifindicated. Resident#138 is having the dermasavers applied in accordance with the plan of care. ***How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?*** Other residents that have the potential to be affected have been identified by: All residents will be reviewed to assure that they are receiving services in accordance with the plan of care. ***What measures will be put into place or what systemic changes will be made toensure that the deficient practice does not recur?*** The measures or systematic changes that have	07/16/2012

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	rolling walker, and assistance of one for ambulating. Resident #73 had a care plan for nutrition, dated 4/6/12, which indicated the resident had the potential for alteration in nutrition related to diagnosis: congestive heart failure, atrial fibrillation, hypertension, diabetes mellitus and the potential for increased constipation due to the number of pain medications. The goals indicated an intake of 75 - 100% for meals, weight stable, labs within normal limits, no signs or symptoms of edema, and no signs or symptoms of swallowing or chewing problems. The interventions included the resident had a mechanical soft diet with ground meat ordered, the resident's food and fluid intake would be monitored, the resident would be provided supplements between meals [Boost Glucose Control 2 times a day], the resident's weight would be monitored weekly to ensure the resident had no significant weight changes, the resident's labs would be monitored, and the resident would be provided with HS [hour of sleep] snacks. During interview, on 6/7/12 at 8:26 a.m., CNA #3 indicated Resident #73 was fed at times and needed cueing		been put into place to ensure that the alleged deficient practice does not recur include: An in-service will be conducted for all nursing staff related to the importance of following the plan of care when providing services tothe residents. The in-service includes providing the bedtime snacks, replacement meals, if indicated, and application of dermasavers inaccordance with the plan of care. The CNA assignments sheets have been reviewed to assure that they accurately reflect the services to be provided to the residents in correlation with the plan of care. Nurses will be responsible for assuring that all services provided are completed in accordance with the care plans on their designated shifts via observation. Please see below for monitoring as part ofthe QA process. ***How will the corrective action be monitored to ensure the deficient practice willnot recur, ie, what quality assurance program will be put into place?*** The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly reviews 5 residents related to providing services in accordance with theplans of care. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be	

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	when she fed herself. The HS Snack checklist indicated the resident had not received a HS snack, except on 4/11/12, 4/13/12, 5/16/12, 5/21/12, and 6/4/12. The Hydration/Snack Tracker indicated the resident was not offered a snack at 8:00 p.m. from 6/1/12 through 6/5/12. The Food Intake Record, dated April 2012, and May 2012, indicated Resident #73 did not receive a replacement or supplement for the food she did not eat. Interview with the R.D. [registered dietician], on 6/8/12 at 9:15 a.m., indicated the resident had a basket of snacks in her room and the HS Snack checklist only indicated the resident's basket was replenished. The R.D. indicated she did not track snack consumption of residents. During interview with Resident #73 on 6/8/12 at 9:30 a.m., she indicated she was unable to reach the basket on her table for her snack. She indicated her daughter would give her snacks from the basket when she came to visit, but her daughter did not visit her at bedtime and her hours of visitation varied according to her work schedule. She also indicated she did		immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed. ***The date the systemic changes will be completed:*** 7-16-12	

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	not receive a supplement or replacement for uneaten meals. 2. On 6/5/12 at 2:50 p.m., Resident #138 was observed in a wheelchair in her room. She had short sleeves on. A two centimeter bruise was observed on her left arm. Resident #138's clinical record was reviewed on 6/6/12 at 1:40 p.m. Diagnoses included, but were not limited to, dementia, coronary artery disease, Parkinson's disease, diabetes mellitus, and hypertension. A care plan dated 5/18/12, for being at risk for abnormal bleeding or hemorrhage because of anticoagulant usage included, but was not limited to, the following: Monitor for and report to nurse any of the following signs and symptoms of bleeding: -bleeding gums -nose bleeds -unusual bruising -tarry, black stools -pink or discolored urine A care plan dated 5/18/12, for being at risk for developing complications related to the needing total assistance in Activities of Daily Living included, but was not limited to, the following:			

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	155773	A. BUILDING 00 B. WING	06/13/2012

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	-Broda chair for comfort -active ROM [range of motion] BU [bilateral upper] and L [lower] extremities to help with stiffness -Derma Savers [sleeve like padded covers for arms] to BUE [bilateral upper extremities] when out of bed to protect skin. Physician's orders dated 5/17/12, included the orders for "May use sit to stand lift PRN [as needed] for transfers," and "Derma Savers to bil. UE as a D.M. to protect skin when OOB [out of bed]." Resident #138 was observed on 6/6/12 at 1:15 p.m., up in the Broda chair. She complained of being cold. She was wearing short sleeves with no Derma Savers. On 6/6/12 at 1:25 p.m., CNAs #1 and #2 were observed to use a gait belt and transfer Resident #138 to the toilet. The resident had long pants on, socks and shoes. She was observed to not bear much weight. According to the CNAs, she sometime did better. Some bruising was observed on the right rear calf and side of the leg. On 6/7/12 at 9:17 a.m., the resident was observed in the exercise room			

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	passively observing. She was wearing 3/4 length sleeves and capris pants. No Derma Savers were observed. On 9:21 a.m., the Derma Savers were observed on a shelf behind the toilet in the resident's bathroom. On 6/7/12 at 10:35 a.m., the resident was observed in a small group activity, sensory stimulation. She had a lightweight jacket on. On 6/7/12 at 4:15 p.m., the resident was observed seated in lobby with skirt on. No Derma Savers were observed on the upper extremities. She did have the Derma Savers on her legs. On 6/8/12 at 10:50 a.m., the resident was observed lying in bed. She had short sleeves on and was observed picking at her coverings. No Derma Savers were on her arms. Derma Savers were observed on her legs. 3.1-35(g)(2)			

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F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview and record review, the facility failed to ensure 1 of 3 residents reviewed for skin conditions, in the sample of 3 who met the criteria for review of skin conditions, received appropriate treatment and services to prevent further bruising in accordance with the plan of care, in that protective sleeves were not used. (Resident #138) Finding includes: On 6/5/12 at 2:50 p.m., Resident #138 was observed in a wheelchair in her room. She had short sleeves on. A two centimeter bruise was observed on her left arm. Resident #138's clinical record was reviewed on 6/6/12 at 1:40 p.m. Diagnoses included, but were not limited to, dementia, coronary artery disease, Parkinson's disease, diabetes mellitus, and hypertension.	F0309	**F309** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** It is the practice of this facility to assure that all residents receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment. The correction action taken for those residents found tobe affected by the alleged deficient practice include: Resident#138 now has protective sleeves in place in accordance with the plan of care. ***How will otherresidents having the potential to be affected by the same deficientpractice be identified and what corrective actions will be taken?*** Other residents that have the potential to be affected will be identified by: All residents will be reviewed to assure that they are receiving service sin accordance with the plan of care including but not limited to protective sleeves. ***What measures will be put into place or what systemic***	07/16/2012

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	A care plan dated 5/18/12, for being at risk for abnormal bleeding or hemorrhage because of anticoagulant usage included, but was not limited to, the following: Monitor for and report to nurse any of the following signs and symptoms of bleeding: -bleeding gums -nose bleeds -unusual bruising -tarry, black stools -pink or discolored urine A care plan dated 5/18/12, for being at risk for developing complications related to the needing total assistance in Activities of Daily Living included, but was not limited to, the following: -Broda chair for comfort -active ROM [range of motion] BU [bilateral upper] and L [lower] extremities to help with stiffness -Derma Savers [sleeve like padded covers for arms] to BUE [bilateral upper extremities] when out of bed to protect skin. Physician's orders dated 5/17/12, included the orders for "May use sit to stand lift PRN [as needed] for transfers," and "Derma Savers to bil. UE as a D.M. to protect skin when OOB [out of bed]."		***changes will be made to ensure that the deficient practice does not recur?*** The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include: An in-service will be conducted for all nursing staff related to the importance of following the plan of care when providing services to the residents. The in-service will include application of protective sleeves in accordance with the plan of care. The CNA assignment sheets have been reviewed to assure that they accurately reflect the services to be provided to the residents in correlation with the plan of care. Nurses will be responsible for assuring that all services provided are completed in accordance with the care plans on their designated shifts via observation. Please see below for monitoring as part of the QA process. ***How will the corrective action be monitored to ensure the deficient practice willnot recur, ie, what quality assurance program will be put into place?*** The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that will be utilized to observe for the provision of services in accordance with the plan of care. The tool will randomly review 5 residents to	

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	Resident #138 was observed on 6-6-12 at 1:15 p.m., up in the Broda chair. She complained of being cold. She was wearing short sleeves with no Derma Savers. On 6-6-12 at 1:25 p.m., CNAs #1 and #2 were observed to use a gait belt and transfer Resident #138 to the toilet. The resident had long pants on, socks and shoes. She was observed to not bear much weight. According to the CNAs, she sometime did better. Some bruising was observed on the right rear calf and side of the leg. On 6-7-12 at 9:17 a.m., the resident was observed in the exercise room passively observing. She was wearing 3/4 length sleeves and capris pants. No Derma Savers were observed. On 9:21 a.m., the Derma Savers were observed on a shelf behind the toilet in the resident's bathroom. On 6/7/12 at 10:35 a.m., the resident was observed in a small group activity, sensory stimulation. She had a lightweight jacket on. On 6/7/12 at 4:15 p.m., the resident was observed seated in lobby with		assure that the residents are receiving the services as identified. The Directorof Nursing, or designee, will complete this audit weekly x3, monthlyx3, then quarterly x3. Any issue identified will be immediatelycorrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed. ***The date the systemic changes will be completed:*** July16, 2012	

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	skirt on. No Derma Savers were observed on the upper extremities. She did have the Derma Savers on her legs. On 6/8/12 at 10:50 a.m., the resident was observed lying in bed. She had short sleeves on and was observed picking at her coverings. No Derma Savers were on her arms. Derma Savers were observed on her legs. 3.1-37(a)			

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F0325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, interview, and record review, the facility failed to ensure 2 of 3 residents reviewed for significant weight loss in the sample of 16 who met the criteria for review of nutrition, received appropriate treatment and services to prevent weight loss, in that evening snacks were not provided. (Resident #31, Resident #73) Findings include: 1. Resident #73's clinical record was reviewed on 6/6/12 at 2:45 p.m. Resident #73 was admitted with diagnoses of, but not limited to, general debility and diabetes mellitus. Resident #73 was currently receiving Lantus insulin, Januvia, and Glucophage which are used for the treatment of diabetes mellitus. A physician's order dated 4/6/12	F0325	**F325 *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** It is the practice of Solarbron to assure that each resident identified as having significant weight loss have appropriate treatment and services in place to assist with preventing further weight loss. The correction action taken for those residents found to be affected by the alleged deficient practice include: Resident#31 now has orders for nutritional supplements to assist in the prevention of further weight loss. Resident#73 is receiving nutritional supplements as ordered. This resident isalso receiving replacements for uneaten meals. Snacks are availablewithin her reach. ***How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?*** Other	07/16/2012

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	indicated Resident #73 was to be weighed daily. Resident #73 had a physician's order indicating the resident was to be up with a gait belt, rolling walker, and assistance of one for ambulating. Resident #73 had a care plan for nutrition, dated 4/6/12, which indicated the resident had the potential for alteration in nutrition related to diagnosis: congestive heart failure, atrial fibrillation, hypertension, diabetes mellitus, and the potential for increased constipation due to the number of pain medications. The goals indicated an intake of 75 - 100% for meals. weight stable , labs within normal limits, no signs or symptoms of edema, and no signs or symptoms of swallowing or chewing problems. The interventions included the resident had a mechanical soft diet with ground meat ordered, the resident's food and fluid intake would be monitored, the resident would be provided supplements between meals [Boost Glucose Control 2 times a day], the resident's weight would be monitored weekly to ensure the resident had no significant weight changes, the resident's labs would be monitored, and the resident would be provided with HS [hour of sleep] snacks.		residents that have the potential to be affected have been identified by: All residents will be reviewed to assure that if needed, they are receiving nutritional supplements to assist with the prevention of weight loss in accordance with the physician's orders. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include: Nursing staff will be in-serviced related to assuring that nutritional supplements, replacements for uneaten meals, and bedtime snacks are offered in accordance with the plan of care and/or physician'sorders. The nurses will be in-serviced related to identifying weight loss in a timely manner and assuring that the physician is notified for any recommendations. The interdisciplinary team will be reviewing weights weekly to assure that all residents showing significant weight loss have appropriate interventions in place. In addition, the Dietician will be providing nursing administration a list of recommendations so that appropriate follow-up is assured. ***How will the corrective action be monitored to ensure the deficient practice will not recur, ie, what quality assurance***	

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	During interview 6/7/12 at 8:26 a.m., CNA #73 indicated Resident #73 was fed at times and needed cueing when she fed herself. The Nutritional Progress Note, dated 5/4/12 at 1:03 p.m., indicated Resident #73 had no swallowing or chewing difficulty and consumed 50 - 100 % of her meals daily. The Nutritional Progress Note, dated 5/31/12 at 12:40 p.m., indicated the resident received Boost Glucose Control 2 times a day but had been refusing it. The note also indicated the resident eats in the dining room and received a mechanical soft diet with ground meat due to loose fitting dentures. The Nutritional Progress Notes obtained from the DoN [Director of Nursing] on 6/8/12 at 10:52 a.m., indicated Resident #73 was hospitalized from 4/4/12 - 4/6/12 and while hospitalized Resident #73 had a swallowing evaluation completed. Upon returning from the hospital, Resident weight was 109.8 pounds. On 4/11/12, the Nutritional Progress Note indicated the resident's was on a CCHO [controlled carbohydrate] diet with a food intake was 80 - 100% and		***program will be put into place?*** The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement tool has been established that randomly reviews residents who have been identifed with signifcant weightloss/gain. This tool will randomly review 5 residents. TheRegistered Dietician, or designee, will complete the tool weekly x3,monthly x3, then quarterly x3. Any issues identified will beimmediately addressed. The Quality Assurance Committee will reviewthe tool at the scheduled meeting following the completion of the tool with recommendations as needed. ***The date the systemic changes will be completed:*** July16, 2012	

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	a fluid intake of 120 - 480 ml [milliliter] for meals. The Nutritional Progress Note indicated on 4/12/12 at 4:00 p.m., the resident's diet was changed to a mechanical soft, and the resident's care plan was updated. On 4/18/12 at 1:45 p.m., the Nutritional Progress Note indicated the resident had a decline from 4/6/12 and Occupational Therapy was indicated for modified utensils and Boost Glucose Control 2 times a day was ordered. On 4/20/12 at 1:31 p.m., the Nutritional Progress Note indicated the resident needed cueing, her tray setup, and encouragement for meals. Her weight on 4/19/12 was 105.4 pounds with a 4.4 pound weight loss and a new order for Boost Glucose Control 2 times a day was ordered. The Nutritional Progress Note from 5/4/12 indicated the resident ate in her room and was a slow eater. The note indicated the resident had no problem with swallowing or chewing and her food intake was 50 - 100% at meals. The note indicated the resident drank 0 - 50% and her weight was stable at 105.4 pounds.			

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	The Nutritional Progress Note, dated 5/31/12 at 12:40 p.m., indicated Resident #73 weight was 99 pounds with a 6.6 pound weight loss in the past month. The note indicated Resident #73 was refusing her Boost Glucose Control 2 times a day. The note indicated the dietician would contact the resident's family for wishes for the resident. The note indicated the resident's intake was fair and the resident was eating in the dining room. Resident #73 had a BMP [Basal Metabolic Profile] on 5/11/12 which indicated a blood glucose of 163 [normal between 70 -99], a BUN [Blood Urea Nitrogen] of 21 [normal between 6 -20], and a CO2 [Carbon Dioxide] level of 35 [normal levels between 20 - 33]. Resident #73's BMP on 6/4/12 indicated a glucose of 113. The HS Snack checklist indicated the resident had not received a HS snack except on 4/11/12, 4/13/12, 5/16/12, 5/21/12, and 6/4/12. The Hydration/Snack Tracker indicated the resident was not offered a snack at 8:00 p.m. from 6/1/12 through 6/5/12. The Food Intake Record, dated April 2012, and May 2012, indicated			

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	Resident #73 did not receive a replacement or supplement for the food she had not ate.. During interview with the R.D. [registered dietician], on 6/8/12 at 9:15 a.m., the R.D. indicated the resident had a basket of snacks in her room and the HS Snack checklist only indicated the resident's basket is replenished. The R.D. indicated she did not track snack consumption of residents. During interview on 6/8/12 at 9:30 a.m., Resident #73 indicated she was unable to reach the basket on her table for her snack. She indicated her daughter would give her snacks from the basket when she came to visit but her daughter did not visit her at bedtime and her hours of visitation varied according to her work schedule. She also indicated she did not receive a supplement or replacement for uneaten meals. 2. Resident #31's clinical record was reviewed on 6/6/12 at 2:45 p.m. The record indicated the resident was re-admitted on 5/11/12. Diagnoses included, but were not limited to, general debility, status/post valve replacement on coumadin [blood thinner], urinary retention, congestive heart failure, hypertension, chronic			

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	back pain, anemia, pneumonia, depression, and heart disease. Physician's orders, signed 5/29/12, indicated the resident was on a regular diet as of 5/16/12. Orders for Speech Therapy for swallow evaluation and treatment were obtained on 5/22/12. The care plan for alteration in nutritional status, dated 5/15/12, included, but was not limited to, the following: -regular diet 5/16/12 -monitor food/fluid intake -monitor weight daily/? to ensure no significant weight changes -visit resident to determine likes/dislikes -provide select menu for food preferences On 6/7/12 at 12:08 p.m., the resident's lunch tray was observed on the overbed table, covered. A laboratory technician was drawing blood. The Speech Therapist entered the room. She was interviewed on 6/7/12 at 12:12 p.m. She indicated she evaluated the resident for swallowing at first, but discontinued because he was swallowing well and was only treating him for cognitive			

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	improvement. She indicated she was just checking on him that day because he had a spell where he was slurring that morning and she was concerned. Dietitian notes dated 5/31/12 at 12:35 p.m. indicated the following: "Resident's wt [weight] 5/30/12 189.8 lbs [down] 15 lbs X 1 wk. On regular diet with intakes 50-100% of meals. On Lasix [diuretic medication] 20 mg QD (has been since adm). IBW [Ideal Body Weight] 200 +/- 5 lbs. Will have nursing assess and notify MD." 6/4/12 1047 [10:47 a.m.] "...Wt 6/3/12 191.2 lbs [up] 1.4 lbs X 4 days." The nurses' notes were reviewed, at that time, and there was no indication the physician was notified or nursing assessed. LPN #1 was interviewed on 6/7/12 at 2:25 p.m. She indicated the resident was a daily weight and his weight was 187.2 pounds on that date. On 6/7/12 at 4:00 p.m., Resident #31's record was reviewed again. There was no indication the physician was called for weight loss. A Registered Dietitian note, dated 6/7/12 at 11:03 a.m., indicated,			

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	"Resident's wt 6/6/12 186.2 lbs [down] 3.6 lbs X 1 wk, [down] 22.2 lbs since adm [admission]. Will request med pass [nutritional supplement] 90 cc [cubic centimeters] TID [three times a day] d/t [due to] wt. loss. Regular diet. Intakes generally 50-100% of meals." On 6/8/12 at 10:00 a.m., LPN #2 was interviewed. She indicated when the dietitian made recommendations, she often faxed them herself to the physician. She reviewed the record to see if the physician had been notified on 5/31/12 about the resident's weight loss. She reviewed a folder with faxes in it. She indicated he was not eating well when he first got to the facility and had a lot of fluid taken off during his last hospitalization, prior to admission. She further indicated she usually worked evenings, so notification of the physician was not always passed on. On 6/8/12 at 10:10 a.m., the Registered Dietitian was interviewed and indicated she reviewed the resident last week and wrote the note and asked nursing to assess the resident and notify the physician. She indicated she was then off work. She re-evaluated him this week and			

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	he had more weight loss. She recommended adding med pass supplement due to continued weight loss. She indicated she spoke to LPN #1, the nurse that day, and LPN #1 said she had a call out to the doctor and would also request the supplement for the resident when the doctor called back. Review at the time revealed no documentation of the physician being notified of the weight loss. He had been notified of a change in behavior and had ordered some labwork. No orders for supplement were noted. 3.1-46(a)(1)			

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F0329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on record review and interview, the facility failed to ensure 1 of 10 residents reviewed for unnecessary medications had indications for use and follow-up on the use of a sleep/pain medication, in that the medication was given without documentation of reasons, alternatives attempted, and follow-up on effectiveness. (Resident #137) Finding includes:	F0329	**F329** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** It is the practice of this facility to assure that residents are assessed appropriately related to psychoactive medication usage. The correction action taken for those residents found to be affected by the alleged deficient practice include: Resident #137 no longer resides at the facility. ***How will other residents having the potential to be affected by***	07/16/2012

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	Resident #137's clinical record was reviewed on 6/6/12 at 4:07 p.m. The resident's diagnoses included, but were not limited to, atrial fibrillation, altered mental status, arthritis, hypertension, and thyroid disease. The resident had admission physician's orders, dated 5/25/12, for Tylenol PM 25-500 milligrams one by mouth at bedtime as needed for insomnia. The Medication Administration Record for May, 2012 indicated the Tylenol PM was given on 5/27/12, 5/29/12, and 5/30/12. There was no documentation of the reason for the medication or the effect. The nurses' notes were reviewed and failed to indicate the reason, any other interventions, or the effect of the medication. During interview with RN #1, on 6/7/12 11:00 a.m., she indicated "if give prns [as needed medications], should write on the back [of the Medication Administration Record] why and whether or not they were effective." 3.1-48(a)(6)		***the same deficient practice be identified and what corrective actions will be taken?*** Other residents that have the potential to be affected have been identified by: All residents that receive sleep medications will be reviewed to assure that alternative interventions are attempted and unsuccessful prior to using. All residents will be reviewed that receive PRN pain medications to assure that proper documentation is present on the back of the MAR and or Pain Tracking Form to substantiate the reason for the administration of the medication. ***What measures will be put into place or what systemic changes will be made toensure that the deficient practice does not recur?*** The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include: Nurseswill be in-serviced relating to proper documentation related to medication administration. The in-service will include informationrelated to PRN sleep medications and PRN pain medication. ***How will the corrective action be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place?*** The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement tool	

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			has been established that randomly reviews residents who have orders for PRN sleep and pain medications to assure that they are documented properly in accordance with the guidelines. This tool will randomly review 5 residents. The Director of Nursing, or designee, will complete the tool weekly x3, monthlyx3, then quarterly x3. Any issues identified will be immediately addressed. The Quality Assurance Committee will review the tool atthe scheduled meeting following the completion of the tool with recommendations as needed. ***The date the systemic changes will be completed:*** July16, 2012	

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F0364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview, and record review, the facility failed to ensure 9 of 11 residents reviewed for food quality, in the sample of 25 who met the criteria for review of food quality, received food at a palatable temperature. (Resident #44, #142, #143, #144, #145, #146, #147, #148, #149) Findings include: 1. During an interview on 6/5/12 at 8:35 a.m., Resident #143 indicated the hot food was sometimes cold when she got it and was not seasoned to her liking. During an interview on 6/5/12 at 9:37 a.m. Resident #144 indicated the hot food was sometimes cold. During an interview on 6/5/12 at 10:23 a.m., Resident #142 indicated the temperature of the hot food was not hot enough.	F0364	**F364** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** It is the practice of this facility to assure that all meals are served to residents within appropriate temperature guidelines. The corrective action taken for those residents found to be affected by the alleged deficient practice include: Resident#44 no longer resides in the facility. Residents# 142, #144, #145, #146, #147, #148, and #149 are receiving all meals at appropriate temperatures. ***How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?*** Other residents that have the potential to be affected have been identified by: Because of the systems that have been implemented, all residents are receiving meals at the appropriate temperatures. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** The measures or systematic changes	07/16/2012

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	During an interview on 6/8/12 at 8:02 a.m., Resident #145 indicated the food on his breakfast tray was edible but cold. Resident #145 indicated it was cold most days, but his wife was usually visiting with him during meal times and she would heat the food in the microwave for him. An observation was made on 6/8/12 at 7:49 a.m. of meal trays being delivered to resident rooms on the east hall, at 7:56 a.m. When the last tray was delivered to the last resident on the east hall, the test tray was removed from the tray cart and the temperatures of the foods were taken and documented as follows: scrambled eggs 94.8 degrees, milk in the carton 54.3 degrees, orange juice in a glass 53.4 degrees, and bacon cold to the touch. A document, titled Dining Atmosphere and dated 2010, provided by the Registered Dietician, indicated it was the facility's policy to serve hot food hot and cold food cold "as acceptable to the individual being served."		that have been put into place to ensure that the deficient practice does not recur include: The dietary staff will be in-serviced to reiterate the practice of taking temperatures of the food prior to serving the food in accordance with the facility policy. Nursing staff will be in-serviced related to assuring that there is timely delivery of meals service to assure that food remains at appropriate temperatures at that time. Please refer to monitoring systems to assure compliance with food temperatures including resident interviews. **How will the corrective action be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place?** The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement tool has been established that randomly reviews food temperatures. This tool will randomly review test tray sand verify that temperature logs are complete. The tool will also interview residents to assure that the food is being served at appropriate temperature. The Dietary Manager, or designee, will complete the tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately addressed. The QualityAssurance Committee will review the tool at the scheduled	

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	2. Resident #44 was interviewed on 6/5/12 at 9:07 a.m. indicated the food could be warmer. On interview on 6/5/12 at 12:15 p.m., Resident #44 indicated lunch was warm and good on that day but this was usually not the case. On interview with Resident #44 on 6/7/12 at 12:00 p.m., he indicated he did not receive ketchup for his french fries but his food was hot. The resident indicated his food is usually not warm enough when he receives it. Interview with Resident #149 on 6/5/12 at 9:46 a.m. she indicated she ate her meals in the rehabilitation dining room and her food is not hot enough. She indicated the staff usually had to reheat her food in the microwave oven. On interview on 6/5/12 at 10:04 a.m., Resident #44 indicated she ate in the dining room and her food is usually too cool when she receives it. 3. During confidential interview with Resident #146 on 6/5/12, the resident indicated, "getting this far down [the		meeting following the completion of the tool with recommendations as needed. ***The date the systemic changes will be completed:*** July16, 2012	

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	hall], ice cream is melted and the meat's not warm enough." During confidential interview with Resident #147 on 6/5/12, the resident indicated food was not always warm when she received it. During confidential interview with Resident #148 on 6/5/12, the resident indicated the food was not always hot. On 6/7/12 at 11:41 a.m., lunch trays were observed being passed on the halls. At 11:50 a.m., when all the trays had been passed, a test tray was tested for food temperatures. The cottage cheese measured 58 degrees. 3.1-21(a)(2)			

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F0431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure medications were stored safely and multi-dose medication	F0431	**F431** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** It is the practice of	07/16/2012

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	containers were disposed of timely, for 3 of 27 stage 2 sample residents, in that medications were in sight in their rooms, and eye drops were opened and kept beyond 30 days. Findings include: 1. Resident #135's room was observed on 6/4/12 at 9:05 a.m. A bottle of Pataday [medication for eye itching related to allergies] eye drops was observed at the bedside on a table. 2. Resident #137's room was observed on 6-5-12 at 9:35 a.m. A bottle of Genteel [lubricant eye medication] eye drops was observed on the table beside the resident's chair. She indicated she used them four times a day. 3. The East Unit medication cart was observed on 6/7/12 at 3:00 p.m. Resident #73 had Lumigan [used to treat glaucoma] eye drops dated as opened on 4/28/12. The same resident had Combigan eye drops [for glaucoma], dated as opened on 4/21/12. LPN #2 indicated, during interview at that time, the eye drops were only to be used for 30 days after opening.		Solarbron to assure that all drugs and biologicals are secure appropriately and disposed of when expired. The correction action taken for those residents found to be affected by the alleged deficient practice include: Resident #135 has medication stored securely. Resident #137 has medication stored securely. Resident #73 eye drops that had expired have been disposed of properly. ***How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?*** Other residents that have the potential to be affected have been identified by: All residents have the potential to be affected. The nurses will be in-serviced to assure that medications are secure and disposed of properly when expired. Please refer to systems below and means of monitoring. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include: The nurses will be in-serviced relating to the importance of assuring that all drugs and biologicals are locked securely unless within direct supervision of the nurse. The in-service will	

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	3.1-25(j) 3.1-25(k) 3.1-25(l)		address assuring that the medications are secure and that any expired medications are disposed of properly. Nursing administration, via routine rounds will be observing to assure that medications are kept secure. In addition, the consultant pharmacist will be asked to assist with the monitoring of expired medications. **How will the corrective action be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place?** The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that will be utilized to randomly review throughout theweek to assure that medications are secured properly. The tool will also randomly review to assure that there are no expired medications identified in the medication cart. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any areas identified via the audit will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed. ***The date the systemic changes will be completed:*** July16, 2012	

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F0441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation and record review, the facility failed to ensure	F0441	**F441** ***What corrective action(s) will be accomplished for those***	07/16/2012

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	infection control procedures were followed for 1 of 5 residents observed for personal care in that, glove use was not done as required. (Resident #73) Findings include: On 6/7/12 at 8:25 a.m., CNA #3 was observed giving Resident #73 a bath. CNA #3 had washed her hands and applied her gloves. CNA #3 placed a dry, clean towel under Resident #73's legs and removed the resident's gripper socks and TED [thromboembolic deterrent] hose from the resident's lower legs and feet. CNA #3 washed the resident's lower legs and feet and then dried them. While wearing the same gloves, CNA #3 applied lotion to the resident's lower legs and reapplied the resident's TED hose. The CNA removed the washcloths and towel. The resident was assisted to the side of her bed, placed a gait belt around the resident's waist, and applied her shoes. The resident was ambulated to the bathroom with her rolling walker and assistance of the CNA. The CNA changed her gloves and washed her hands. CNA #3 placed the gait belt around the resident's waist and assisted the resident onto the commode. CNA #3 removed the		***residents found to have been affected by the deficient practice?*** It is the practice of Solarbron to assure that all procedures are conducted in a manner that is in accordance with infection control guidelines. The corrective action taken for those residents found to be affected by the alleged deficient practice include: Resident #73 is now receiving services in a manner that follows acceptable parameters of infection control. ***How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?*** *Other residents that have the potential to be affected have been identified by:* All residents are now receiving services in a manner that follows acceptable parameters of infection control. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include: An in-service will be conducted for all nursing staff relating to proper infection control practices. The in-service addresses proper handwashing and proper changing of gloves. The facility will be randomly observing staff that is providing services to	

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	155773	A. BUILDING 00 B. WING	06/13/2012

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	resident's wet brief. While wearing the same gloves, CNA #3 proceeded to wash the resident's bilateral axillary areas. Her back and front torso were washed and dried. Deodorant was applied by the CNA after drying her bilateral axillae. CNA #3 placed the gait belt around the resident's waist and stood the resident from the commode. While wearing the same gloves, CNA washed and dried the resident's periarea and buttocks and applied cream to the resident's buttocks. The resident's upper legs were not washed. CNA #3 sat the resident back onto the commode. The CNA obtained the resident's clothes and wheelchair and brought the items into the bathroom. CNA #3 proceeded to place the resident's clean clothes and clean brief onto the resident. After Resident #73's clothing was applied, the resident was placed into her wheelchair with the assistance of CNA #3. At this time, CNA #3 removed her gloves and washed her hands. The policy on use of gloves, dated 2003, and obtained on 6/8/12 at 12:23 p.m. from the R.D. [registered dietician], indicated gloves should be worn for hand contaminating activities, handling soiled linen, when touching body fluids, excretions,		assure that proper infection control protocol is followed in accordance with the facility policy. ***How will the corrective action be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place?*** The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly observes 5 nursing staff members related to following of proper infection control procedures during the provision of services. TheDirector of Nursing, or designee, will complete this tool weekly x3,monthly x3, then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed. ***The date the systemic changes will be completed:*** 7-16-12	

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	secretions, and mucous membranes. The policy indicated hands should be washed when activity is completed and when the integrity of the glove is in doubt. The policy indicated gloves should be used for handling soiled linen, when touching body fluids, and for hand contaminating activities. The policy on handwashing, dated 2003 and obtained on 6/8/12 at 12:23 p.m. from the R.D., indicated hands should be washed after contact with resident's body secretions and whenever hands are soiled. 3.1-18(l)			
R0000	The following State Residential Findings were cited in accordance with 410 IAC 16.2-5	R0000	Bysubmitting the enclosed material we are not admitting the truth oraccuracy of any specific findings or allegations. We reserve theright to contest the findings or allegations as part of anyproceedings and submit these responses pursuant to our regulatoryobligations. The facility request that the plan of correction beconsidered our allegation of compliance effective July 16, 2012 tothe annual licensure survey conducted on June 4 through June 13, 2012	

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R0027	410 IAC 16.2-5-1.2(b) Residents' Rights - Deficiency (b) Residents have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Residents have the right to exercise their rights as a resident of the facility and as a citizen or resident of the United States. Based on observation, interview, and record review, the facility failed to ensure 3 of 5 residents observed for care in a sample of 7 were not able to exercise their right to determine their waking time. (Residents #206, #214, #228) Findings include: 1. The clinical record of Resident #214 was reviewed on 06/11/12 at 1:30 p.m. The record indicated the diagnoses included, but were not limited to, atrial fibrillation with bradycardia [a heart condition with low pulse rate]. During the initial tour on 06/11/12 at 9:38 a.m., RN #1 indicated Resident #214 was interviewable and required the assistance of one staff for ADL's [Activities of Daily Living] and mobility. The Noc [Night Shift] Care sheets-200 unit provided by RN #1 on 06/11/12 at 10:30 a.m. indicated,	R0027	**F027** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** *It is the practice of Solarbron to assure that resident's rights are honored related to their choice for waking time. The correction action taken for those residents foundto be affected by the alleged deficient practice include:* Residents#206, #214, and #228 are awakened as per their choice. ***How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?*** Other residents that have the potential to be affectedhave been identified by: All residents will be reviewed and are being awakened in accordance with their choice. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? T***he measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include:	07/16/2012

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	"[name of Resident #214] Noc [Night shift]-get up at 5:30 am [sic] & [and] dressed T-W-F-Sat-Sun [Tuesday, Wednesday, Friday, Saturday, Sunday]." The Daily Care Sheets, provided by RN #1 on 06/11/12 at 10:30 a.m., indicated, "[name of Resident] Noc to get up & dressed (Non-Hospice days)." Resident #214 was observed on 06/12/12 at 10:00 a.m. sitting in a wheelchair in his room. During an interview, at that time, Resident #214 indicated staff entered his room early the morning to get up for the day. Resident #214 stated, "...but I don't like to get up and not do anything for two to three hours...I don't think it's necessary, they come in and wake me up at 5:00-5:30 a.m....I don't do anything, I just sit here...Their schedule is important, but mine is too..." In an interview with DoN [Director of Nursing] on 06/12/12 at 2:46 p.m., she indicated the list of residents that night shift gets up is "...it's a list of people who are easy to do...not set in stone if they don't want to get up they are supposed to go to the next one...."		All residents have been interviewed and they will be awakened in accordance with their choice. The care sheets have been updated to reflect their choice of awakening. The nurses and CNA's will be in-serviced related to honoring the resident's preferences. ***How will the corrective action be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place?*** The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomlyinterviews 5 residents related to their choices of awakening being honored. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee willreview the tools at the scheduled meetings with recommendations as needed. ***The date the systemic changes will be completed:*** 7-16-12	

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	2. During the initial tour on 06/11/12 at 9:45 a.m., RN #1 indicated Resident #206 liked to get up between 10:00 a.m. to 10:30 a.m. The Daily Care Sheets for Unit 5, provided by RN #1 on 06/11/12 at 10:30 a.m., indicated Resident #206 was independent with toileting, transfers, and assist as needed with ADL's [Activities of Daily Living]. During a medication pass observation on 06/12/12 at 10:25 a.m., LPN #1 was observed to prepare medications for Resident #206. LPN #1 indicated, at that time, the resident was receiving the medications later in the morning because the resident liked to sleep in. On 06/12/12 at 10:35 a.m., LPN #1 was observed to enter the room of Resident #206 and rouse the resident from sleep. Resident #206 indicated, at that time, "I don't want to get up..." LPN #1 was observed to continue to rouse the resident until 10:40 a.m. At that time, the resident was observed to sit on the side of the bed, take the medication, and return to a lying position in the bed. During an interview, at that time, Resident #206 indicated, "I just like to sleep."			

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	3. On 6/11/12 at 2:35 p.m., Resident #228 was observed in his room in a chair with eyes closed, leaned back, wanderguard in place, and call necklace on. An observation was made on 6/12/12 at 09:55 a.m. of Resident #228 in his room, eyes closed, sitting in lazyboy, with wanderguard in place, and call necklace in place. On 6/12/12 at 11:45 a.m., CNA #4 [Certified Nurse Aide] and CNA #5 were observed transferring Resident #228 to the toilet and back to a wheelchair. After toileting, Resident #228 was washing his hands, and he then yawned and stated "they got me up too early." An interview was done with CNA #4 at 6/12/12 at 11:55 a.m. CNA #4 indicated night shift usually gets Resident #228 up in the morning. The CNA indicated it was night shift's responsibility to get as many people up on the unit in the morning as possible, so day shift does not have as many people to get up. A document titled Daily Care Sheets, dated 6/7/12 and provided by the DoN [Director of Nursing], indicated Resident #228 was to be gotten up by the night shift, which is 2:00 a.m. - 6:00 a.m.	R0027	**F027** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** *It is the practice of Solarbron to assure that resident's rights are honored related to their choice for waking time. The correction action taken for those residents foundto be affected by the alleged deficient practice include:* Residents#206, #214, and #228 are awakened as per their choice. ***How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?*** Other residents that have the potential to be affectedhave been identified by: All residents will be reviewed and are being awakened in accordance with their choice. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? T***he measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include: All residents have been interviewed and they will be awakened in accordance with their choice. The care sheets have been updated to reflect their choice of awakening. The nurses and CNA's will be in-serviced related to honoring the resident's preferences. ***How will the***	07/16/2012

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	The policy and procedure for Residential Residents' Rights, provided by the Administrator on 06/11/12 at 10:00 a.m., indicated, "...Residents have the right to ... self-determination, ... inside ... the facility. Residents have the right to exercise their rights as a resident of the facility and as a citizen or resident of the United States...."		***corrective action be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place?*** The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomlyinterviews 5 residents related to their choices of awakening being honored. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee willreview the tools at the scheduled meetings with recommendations as needed. ***The date the systemic changes will be completed:*** 7-16-12	